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Explanation of Medicaid Policy

Drugs with Criteria and Limits

Many drugs in the Medicaid pharmacy program do not require a Prior Authorization (PA), but are still subject to restrictions that are outlined in the Medicaid Pharmacy Services Manual and the Medicaid Physician Services Manual. This section serves as a quick reference for the specific policies that govern coverage of these drugs.

In accordance with the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, Chapter 4-9, Limits on Certain drugs, some drugs are limited by a quantity in any thirty-day period. These drugs do not qualify for early refills, as stated in Chapter 4-7, Early Refills. The limits listed are those approved by the Medicaid Drug Utilization Review (DUR) Board. Physicians and other prescribers who feel that a patient has specific needs that exceed the limits may appeal to the DUR Board. All medications remain subject to all the other requirements of the Utah Medicaid Pharmacy Program, as described in the Utah Medicaid Manual for Pharmacy Services.

Drugs Requiring Prior Authorization

In accordance with the Utah Medicaid Provider Manual for Pharmacy Services, SECTION 2, Chapter 3, certain drugs that are covered by the Medicaid program may require the patient and physician to meet specific criteria and demonstrate medical necessity in order to receive the requested medication. Detailed information regarding prior approval criteria for individual medications and classes of medications is provided in this manual.

Please note that prior authorization for a medication is client specific, pharmacy specific, and product specific. Prior authorization cannot be transferred to another pharmacy, to another product, nor to another strength of a product that has been approved. The prior authorization cannot be transferred to another client.

To initiate a prior authorization request, the physician must gather all of the records that are requested in the criteria set for the medication being prescribed. These records should then be faxed, along with a cover sheet that includes the client's name and client ID, physician's name and telephone number, and (if known) the name and telephone number of the pharmacy that the client would like to use. A fax cover sheet that can be filled out with the requested information is included in the back of the prior authorization section, should you wish to use it. The requests can be faxed to (801) 536-0477.

All injectable products, with the exception of 10ml vials of insulin, require prior authorization under the Non-Traditional Medicaid plan.

Non-Traditional Medicaid has additional restrictions in place. In accordance with the Utah Medicaid Provider Manual for Non-Traditional Medicaid, SECTION 2, Chapter 2-19.2, no lozenges, suckers, rapid dissolve, lollipop, pellets, patches or other unique formulation delivery methodologies developed to garner "uniqueness" will be covered, except where te specific medication is unavailable in any other form (Duragesic and Actiq). Drugs are covered for labeled indications only.

Exceptions to Policy

All requests for exceptions to policy require a petition to the DUR board. DUR meetings are held on the second Thursday of every month. Petitions to the DUR board must be received one week prior to the monthly meeting. Petitions may be faxed to the prior authorization team.

Drugs with Criteria and Limits

ADD/ADHD Medications	
• Amphetamines	Amphetamines: • Age 0-2: Not a covered benefit. • Age 3-5: Immediate-release Adderall and Dexedrine generic formulations are covered - Valid ICD-9 code must be written on the prescription. • Age 6-18: Covered - Valid ICD-9 code must be written on the prescription. • Age 19+: Prior Authorization Required - see page 21.
• Methylphenidate & Derivatives	Methylphenidate & Derivatives: • Age 0-5: Not a covered benefit • Age 6-18: Covered - Valid ICD-9 code must be written on the prescription. • Age 19+: Prior Authorization Required - see page 21. • Daytrana patch requires a prior authorization - see page 21. • Daytrana patch is non-covered under Non-Traditional Medicaid
• Strattera	Strattera: • Covered for ages 6+. • Cumulative limit of 66 capsules in 30 days. • Approved as a stand-alone treatment for ADHD.
Analgesics	
• Celebrex	Celebrex: • Age below 65: Prior Authorization Required - see page 12. • Age 65+: Cumulative limit of 60 capsules in 30 days.
• Tramadol/Ultracet	Tramadol/Ultracet: • Cumulative limit of 180 tablets in 30 days
• Fentanyl Patch	Fentanyl Patch • Cumulative limit of 15 patches in 30 days • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for cancer. • The 100mcg Fentanyl Patch is *only* covered with valid ICD-9 diagnosis code for cancer.
• Fentora	Fentora • Cumulative limit of 120 units in 30 days - Actiq counts towards this limit. • Only a covered benefit if the prescriber provides a valid ICD-9 diagnosis code for cancer.
• Actiq	Actiq • Cumulative limit of 120 units in 30 days - Fentora counts toward this limit. • Only a covered benefit if the prescriber provides a valid ICD-9 diagnosis code for cancer.
• Methadone	Methadone • Cumulative limit of 150 tablets in 30 days. • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for cancer.
• Long-Acting Opioids *(Avinza, Kadian, MS-Contin Oxycontin & generics)*	Long-Acting Opioids • Cumulative limit of 90 tablets in 30 days. • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for cancer.
• Short-Acting Opioids	Short-Acting Opioids • Cumulative limit of 180 tablets in 30 days • The cumulative limit may be overridden if the prescriber provides a valid ICD-9 diagnosis code for cancer.
• Short-Acting Opioid/APAP	Short-Acting Opioid/Apap Combinations • Cumulative limit of 180 tablets in 30 days • The control is on Acetaminophen and may not be overridden for safety reasons.

Drugs with Criteria and Limits	
Atypical Antipsychotics *(Abilify, Clozaril, Geodon, Risperdal, Seroquel, Sybmbyax, Zyprexa)*	• Valid ICD-9 diagnosis code is required on each prescription. • ICD-9 codes may be found in the Utah Medicaid Provider Manual for Physicians Services and Anesthesiology. • ICD-9 code must be correct for the patients age. • Risperdal Consta requires a prior authorization - see page 21.
Benzodiazepines	• Cumulative limit of 120 tablets/capsules in 30 days. • Short acting benzodiazepines that are typically used to treat insomnia are governed by the criteria for sedative-hypnotics. • Prior Authorization required for Xanax XR - see page 22. • Xanax XR is non-covered under Non-Traditional Medicaid.
Bupropion *(Zyban, Wellbutrin)*	• One of two valid ICD-9 diagnosis codes is required on each prescription. • ICD-9 311 indicates depressive disorders. • ICD-9 305.1 indicates smoking cessation. • Wellbutrin XL is non-covered under Non-Traditional Medicaid.
Butalbital Containing Products	• Cumulative limit of 30 tablets in 30 days.
Chantix	• Lifetime limit of 24 weeks of therapy.
Cymbalta	• One of two valid ICD-9 diagnosis codes is required on each prescription. • ICD-9 311 indicates depressive disorders. • ICD-9 729.2 for neuralgias, etc. • The maximum daily dose is 60 mg. Monthly quantity limits are set accordingly.
Diphenoxylate Containing Products	• Cumulative limit of 30 tablets in 30 days.

Inhalers	LIMIT IN ANY 30 DAY PERIOD				
Effective April 1, 2002, the cumulative number of inhalers in any 30-day period is limited for a Medicaid client. The limit is set by class (excepting Foradil and Serevent which are limited by NDC number). This means the highest number in any one class is the maximum. When there are more than two sizes or strengths for a given product, the limit is based on the largest size or strength. There are two groups of inhalers: oral and nasal. For each group, the limits are stated below.					
Inhaler Class	**Generic Name**	**Brand Name**	**Product Size**	**Doses per Inhaler**	**Maximum No. In 30 Days**
Nasal Anti-inflammatory inhalers	beclomethasone	Beconase AQ	25	200	2
	fluticasone	Flonase	16	120	1
	triamcinolone	Nasacort AQ	16.5	120	2
	triamcinolone	Nasacort HFA	9.3	100	3
	flunisolide	Nasarel	25	200	3
	mometasone	Nasonex	17	120	1
	budesonide	Rhinocort AQUA	8.4	120	2

Inhaler Class	Generic Name	Brand Name	Product Size	Doses per Inhaler	Maximum No. In 30 Days
Beta 2 agonists and Sympathomimetic Inhalers	Albuterol	generic	17 gm	200	4
		Proventil	17 gm	200	4
		Proventil HFA	6.7 gm	200	4
		Ventolin	6.8 gm	80	4
			17 gm	200	4
		Ventolin HFA	18gm	200	4
	Formoterol	Foradil		12	1
				60	2
	Metaproterenol	Alupent	14 gm	200	2
	Pirbuterol	Maxair	25.6 gm	300	3
	Pirbuterol	Maxair Autohaler	14 gm	400	1
	Salmeterol	Serevent	6.5 gm	60	1
			13 gm	120	1
		Serevent Diskus		60	1
Anticholinergicic Inhalers	Ipratropium	Atrovent HFA	14 gm	200	2
	Ipratropium / Albuterol	Combivent	14.7 gm	200	2
	Tiotropium	Spiriva	30 cap.	30	1
Anti-Inflammatory Inhalers	Beclomethasone	Qvar 40mg	7.3 gm	100	2
		Qvar 80mg	7.3gm	100	2
	Budesonide	Pulmicort Turbuhaler		200	2
	Flunisolide	AeroBid, AeroBid-M	7 gm	100	2
	Fluticasone MDI	Flovent	13 gm	120	1
				120	1
				120	2
	Fluticasone DPI	Flovent Rotadisk 50 mcg, 100 mcg, and 250 mcg		60	1
				60	1
				60	4
	Triamcinolone MDI	Azmacort	20 gm	240	2
	Fluticasone / Salmeterol DPI	Advair diskus 100/50		60	1
		Advair diskus 250/50		60	1
		Advair diskus 500/50		60	1
Mast cell stabilizer Inhalers	Cromolyn MDI	Intal	8.1 gm	112	3
			14.2 gm	200	2
	Nedocromil MDI	Tilade	16.2 gm	112	3

Drugs with Criteria and Limits

Laxatives • Miralax • Lactulose	Miralax: • Cumulative limit of 1054gm in 30 days • Miralax OTC formulations are not covered. Lactulose: • Cumulative limit of 6,000ml in 30 days • Over 6,000ml in 30 days requires a prior authorization - see page 16.
Levothyroxine Products	• Generic use mandated when AB-rated equivalent exists • Use the table below to determine appropriate substitutions: Drug — Rating Unithroid — AB1,AB2, AB3 Mylan Levothyroxine — AB1,AB2,AB3 Levoxyl — AB1, AB3 Synthroid — AB2 Levo-T — AB2, AB3
Migraine Medications (Triptans) *(Imitrex, Zomig, Amerge, Axert, Maxalt)*	• Cumulative limit of 9 dosage units per 30 days - all forms count towards this limit. • Examples of drugs in this class include Imitrex, Maxalt, and Zomig.
Muscle Relaxants	• Cumulative limit of 30 tablets in 30 days. • Dantrolene, Baclofen, and Tizanidine are not included in this policy.
Prograf (tacrolimus)	• All oral dosage forms are a covered benefit for use as a prophylaxis of organ rejection in allogenic liver transplants only. • All injectable dosage forms are covered in physician office or hospital only.
Proton Pump Inhibitors	• Cumulative limit of 30 units in 30 days. • Prior Authorization required for twice daily dosing - see page 18. • Prilosec OTC prescriptions do not require a PA for twice daily dosing.
Sedative-hypnotics for sleep *(Dalmane, Sonata, Somnote, Halcion, Ambien, Doral, Restoril, Lunesta, Rozerem, and their generics)*	• Cumulative limit of 30 units in 30 days. • Benzodiazepines that are typically used to treat insomnia are considered part of this class.

Drugs Requiring Prior Authorization	
Anti-Emetics • 5HT3's *(Anzemet, Kytril, or Zofran)*	5HT3 Pregnancy Criteria: • Pregnancy related hyperemesis exceeding one week. • Failure to respond to other medications, including at least a trial of pyridoxine and phenothiazines for the current pregnancy. • Has received IV re-hydration with imminent hospital admission if vomiting cannot be otherwise controlled. • Re-authorization requires review and approval by DUR board. 5HT3 Chemotherapy, Radiation, and Post-op Criteria: • Prevention of hyperemesis associated with initial and repeat courses of cancer treatment with chemotherapy. • Prevention of hyperemesis associated with radiation therapy in patients receiving either total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen. • Prevention of post-op hyperemesis. • Re-authorization requires a telephone request from the physician's office.
• Aloxi	Aloxi: • Prevention of acute or delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy. • Must have failed on a 5HT3. • No 5HT3 medications are allowed as rescue drugs. • Authorization is granted for 6 months. Renewal course of chemotherapy following the initial 6 months requires a new authorization.
• Emend	Emend: • Used in combination with corticosteroid and 5HT3 agents to prevent acute and delayed nausea and vomiting associated with initial and repeat doses of highly emetogenic cancer chemotherapy including high-dose Cisplatin. ‣ Patients receiving the following chemotherapy regimens that are classified by the National Comprehensive Cancer Network (NCCN) as high emetic risk may receive Emend as a first-line treatment: ‣ Cisplatin > or = 50mg/m^2 ‣ Cyclophospamide > 1,500mg/m^2 ‣ Dacarbazine ‣ Mechlorethamine ‣ Procarbazine (oral) ‣ Streptozocin ‣ Altretamine ‣ Carmustine > 250mg/m^2 ‣ AC combination defined as either doxorubicin or epirubicin with cyclophosphamide ‣ Patients on other chemotherapy regimens must have failed on a trial of Zofran, Kytril, Anzemet, Aloxi, or other 5HT3 agent. • Initial authorization is for 6 months, 3 doses per chemotherapy session. • Re-authorization requires a telephone request from the physician's office.
Antihistamines, non-sedating *(Allegra, Clarinex, or Zyrtec)*	• Provide documentation stating when and how Loratadine or Alavert has failed. • PA's granted for up to 30 doses in 30 days. • Initial authorization period is one year. • Re-authorization requires a telephone request from the physician's office. • Children under the age of 10 may have Zyrtec liquid without a PA.
Arthritis/Psoriasis Medications • Amevive	Amevive: • Severe chronic plaque psoriasis. • Candidate for systemic or photo-therapy • Lack of other concomitant immunosuppresive agents • Step therapy which includes a trial of Methotrexate, Acitretin (Soriatane), or Methoxaselen, rapid, Oxasoralen-Ultra, and cyclosporin. • Minimum body surface area involvement > 10% • To be given in clinic setting only - provider will bill with J-code 3490 • Initial authorization is given for 12 weekly injections • Additional 12-week course may be initiated provided that CD4+T lymphocyte counts are within normal range and a minimum of 12 weeks have passed since the previous course of treatment. Maximum annual coverage is 24 weeks.

Drugs Requiring Prior Authorization	
• Arava	Arava: • Documented severe rheumatoid arthritis. • Documented history of treatment, incomplete response, or intolerance to Methotrexate. • Documented 6 or more swollen joints and 9 or more tender joints. • Documented rheumatology consultation within the last 60 days. • May not be given with other biological agents such as interferon, experimental medications or combinations. • Initial authorization is for 6 months. • Subsequent PA is for 12 months if the patient has at least 20% documented improvements in 4 of the following 6 areas: tender and swollen joint count, patient and/or global assessment of disease activity, pain, acute phase reactants.
• Enbrel	Enbrel: • Diagnosis of severe rheumatoid arthritis, ankylosing spondylitis, or psoriatic arthritis. • History of treatment, incomplete response or intolerance to methotrexate, AND at least one other DMARD or second-line drug (azathioprine, sulphadiazine, leflunomide, penicillamine, hydroxychloroquinolone, etc). • Documented 6 or more swollen joints and 9 or more tender joints. Write the specific number in notes or letter. • Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition. • Rheumatology consultation within the last 60 days. • May not be given with other biologic agents such as interferon, experimental medications, or combinations. • Initial prior authorization is for 12 weeks. • Subsequent PA is for 12 months if the patient has at least 20% documented improvements in 4 of the following 6 areas: tender and swollen joint count, patient and/or global assessment of disease activity, pain, acute phase reactants. Enbrel for Juvenile Rheumatoid Arthritis (JRA): • Diagnosis of JRA. • Documentation of failed treatment on at least one DMARD. • Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition. • Rheumatology consultation within the last 60 days. • May not be given with other biologic agents such as interferon, experimental medications, or combinations. • Initial prior authorization is for 12 weeks. • Subsequent PA is for 12 months if the patient has at least 20% documented improvements in 4 of the following 6 areas: tender and swollen joint count, patient and/or global assessment of disease activity, pain, acute phase reactants. Enbrel for Plaque Psoriasis: • Diagnosis of plaque psoriasis. • History of incomplete response or intolerance to Methoterxate, Cyclosporin, and Acitrentin (Soriatane). • At least 10% of the body surface area and/or palms, soles, head, neck, or genitalia are affected based on erythema, induration, scaling, patient global assessment of disease activity. • Initial authorization is for a 12-week trial for up to 50mg bi-weekly for 3 months, 48 kits maximum. • Re-authorization may be granted for maintenance dosing if the patient has had at least 50% improvement from baseline. Area and severity based on erythemia, induration, scaling, and patient global assessment of disease activity. Maintenance dosing is one dose up to 50mg weekly, 52 kits per year maximum. • The prescriber must provide an annual letter updating the patient's current response to Enbrel.

Drugs Requiring Prior Authorization	
• Humira	Humira: • Diagnosis of severe rheumatoid arthritis or psoriatic arthritis. • History of treatment, incomplete response or intolerance to methotrexate, NSAID's AND at least one other DMARD or second-line drug (azathioprine, sulphadiazine, leflunomide, penicillamine, hydroxychloroquinolone, etc). • Documented 6 or more swollen joints and 9 or more tender joints. Write the specific number in notes or letter. • Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition. • Rheumatology consultation within the last 60 days. • May not be given with other biologic agents such as interferon, experimental medications, or combinations. • Initial prior authorization is for 12 weeks. • Subsequent PA is for 12 months if the patient has at least 20% documented improvements in 4 of the following 6 areas: tender and swollen joint count, patient and/or global assessment of disease activity, pain, acute phase reactants.
• Kineret	Kineret: • Minimum age requirement: 18 years old. • Diagnosis of severe rheumatoid arthritis. • History of treatment, incomplete response or intolerance to methotrexate, AND at least one other DMARD or second-line drug (azathioprine, sulphadiazine, leflunomide, penicillamine, hydroxychloroquinolone, etc). • Kineret, Enbrel, Remicaid are mutually exclusive. Patients may only be on one of these agents at a time. • Documented 6 or more swollen joints and 9 or more tender joints. Write the specific number in notes or letter. • Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition. • Rheumatology consultation within the last 60 days. • May not be given with other biologic agents such as interferon, experimental medications, or combinations. • Initial prior authorization is for 12 weeks. • Subsequent PA is for 12 months if the patient has at least 20% documented improvements in 4 of the following 6 areas: tender and swollen joint count, patient and/or global assessment of disease activity, pain, acute phase reactants.
• Orencia	Orencia: • Minimum age requirement: 18 years old. • Diagnosis of moderate to severe rheumatoid arthritis. • Must have inadequate response to one or more DMARD's such as Methotrexate OR have inadequate response to one or more TNF's such as anakinra, enteracept, or infliximab. Patient cannot be on a TNF medication. • Documented 6 or more swollen joints and 9 or more tender joints. Write the specific number in notes or letter. • Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition. • Rheumatology consultation within the last 60 days. • To be given in clinic setting only - provider will bill with J-code 3490 and the PA number. • Initial authorization is for 6 months. • Re-authorization requires a letter or progress notes demonstrating improvement or maintenance as a result of using Orencia.
• Raptiva	Raptiva: • Minimum age requirement: 18 years old. • Diagnosis of severe plaque psoriasis. • History of treatment with documentation of incomplete response or intolerance to Methotrexate, Acitretin (Soriatane), Methoxsalen, rapid, Oxsoralen-ultra, or Cyclosporin. • Patient must not be on any concomitant immunosupressive therapy. • Minimum body surface area involvement of 10%. • Initial authorization is for 12 weeks. Subsequent authorizations are granted for one year with documentation of sustained improvement.

Drugs Requiring Prior Authorization	
• Remicaid	Remicaid Ulcerative Colitis or Crohn's disease criteria: • Moderate to severe ulcerative colitis. • Has failed conventional therapy (i.e. 5-aminosalicylates, antibiotics, methotrexate, 6-mercaptopurine, azathioprine, corticosteroids, budesonide) Remicaid Rheumatoid Arthritis and Ankylosing Spondilitis criteria: • Moderate to severely active rheumatoid arthritis. • Given in combination with methotrexate. • To be given in clinic setting only - provider will bill with J-code, J1745, and the PA number. • Initial authorization is given for 6 months. Subsequent authorizations require progress notes demonstrating improvement or maintenance with medication.
Avastin	• Minimum age - 18 years old. • Documentation of diagnosis of metastatic carcinoma of colon or rectum OR non-squamous, non-small cell lung cancer OR macular degeneration. • Initial authorization may be granted for 1 year - renewal requires an updated letter of medical necessity.
Betamethasone Topical *(Luxiq, Olux)*	• Documented failure on generic formulations of betamethasone valerate creams or ointments within the last 12 months. • Initial authorization is given for 6 months. Subsequent authorizations require a telephone request from the physician's office or pharmacy.
Botox	• **Minimum age requirement: 12 years old.** • **Letter of medical necessity must include documentation and history of other treatments.** • **Approved for the following documented diagnoses: cervical dystonia, strabismus, or blepharospasm.** • **Treatment is covered every 3 months, not to exceed 300 units within 90 days.** • **Not approved for the following uses: primary axillary hyperhydrosis, cosmetic procedures, spasticity.** • **Prior authorization is required when the medication is obtained through a pharmacy billing through the Point of Sale system.** • **Initial authorization is given for 6 months. Subsequent authorizations require documentation of patient progress.**
Brand Name Medication	• Provide details of adverse reaction, allergy, or inadequate response • Authorization is granted for one year. Subsequent authorizations require a telephone call from the physician's office or pharmacy.
Brand Name Schedule II Meds	• Documentation from progress notes detailing the patient's allergic skin reaction or adverse reaction. • Authorization is granted for one year. Subsequent authorizations require an updated letter of medical necessity. **NOTE: Prior authorizations for brand name medications in this drug class require physician evaluated, charted documentation of an allergic reaction or adverse reaction. Patient complaints of lack of efficacy, such as "patient said", "patient reports", "doesn't work", or "causes nausea" are not acceptable reasons for failure.**
Cancidas	• Criteria for Invasive Aspergillosis Infection: ‣Minimum age: 18 years old. ‣Failure on Amphotericin B OR ‣Documented lab culture showing that aspergillosis is not sensitive to Amphotericin B or itraconazole. ‣ Criteria for Candida: ‣Minimum age: 18 years old. ‣Diagnosis of esophageal candida, intra-abdominal abscess, peritonitis, or pleural space infections. ‣ Cultures identifying candida. • Also approved for prophylaxis for severely immuno-compromised bone marrow transplant patients with severe graft vs. host disease. • Authorizations are granted for 3-month periods and require documentation of lab cultures and continuing symptoms. • Children with cancer or bone marrow transplants and adults with bone marrow transplants may receive it as needed following hospitalization.

Drugs Requiring Prior Authorization	
Celebrex	• Provide documentation of one of the following diagnoses: ▸ GERD ▸ Barrett's Syndrome ▸ Peptic Ulcer ▸ Gastro-hypersecretory condition or gastric bleeding caused by other NSAIDS (Documentation from progress notes is required). ▸ History of Ulcers ▸ Concomitant anticoagulant therapy ▸ Failure on 3 other NSAIDS (Documentation from progress notes is required) • Prior authorization is not required for age 65+ - see page 3. • Analgesia for 10 days will be granted with a telephone call from the physician's office or pharmacy. • Initial authorization is for one year - renewals require a telephone request from the physician's office or pharmacy.
Combunox	• Components must be unavailable separately. • A telephone call from the pharmacy or provider to the PA team is required. • Authorization is granted for a maximum of 4/day for a 7 day supply. • Re-authorization requires a new PA request.
Cytogam	• Covered for the prophylaxis of cytomegalovirus • Physician must provide documentation of transplantation of kidney, lung, liver, pancreas, or heart. • Initial authorization is for 6 months - renewals require a telephone request from the physician's office or pharmacy.
Diabetes Medications • Byetta • Exubera • Insulin Pens&Cartridges	Byetta: • Minimum age requirement - 17 years old. • The patient cannot be using insulin. Byetta cannot be a replacement for insulin. • Byetta will only be approved as an adjunct therapy in the treatment of Type II Diabetes. • Patient must be taking metformin, a sulfonourea (identify by name) or both OR a TZD (glitazone) alone or in combination with metformin. • The patient cannot be in end-stage renal disease or on dialysis. • The patient may not have a diagnosis of gastroparesis. • Provide information showing a lack of glycemic control. • Initial authorization is for 1 year - renewal requires documentation that the patient is stable on Byetta and is not on insulin. Exubera: • Minimum age requirement - 18 years old. • Diagnosis of Type I or Type II Diabetes. • Not approved for smokers. • Detailed description of medical necessity, including a description of the patient's underlying pulmonary condition. • Documentation of why the patient is unable to use short-acting insulin. Approval will not be granted for patient convenience. • Is not being used in combination with a short-acting insulin (long acting is OK). • Initial authorization is for 1 year - renewals require a letter from the physician showing that the above criteria are still being met. Insulin Pens & Cartridges: • Medicaid will only pay for the insulin cartridge or pen for those that are legally blind. • Initial authorization is for 1 year - renewals require a telephone request from the physician's office or pharmacy.

Drugs Requiring Prior Authorization	
• Symlin	Symlin: • Is being used for Type I or Type II diabetes as adjunct therapy for patients who use mealtime insulin. • Patient has failed desired glucose control despite optimal insulin therapy. • Patient is insulin compliant and does regular insulin monitoring. • Patient has not had a hypoglycemic incident requiring assistance in the last 6 months. • Patient does not have gastroparesis or hypoglycemia. • Has HbA less than 9% • Initial authorization is 1 year - renewals require a telephone call from the physician's office or pharmacy.
Emsam	• Physician documentation from charted progress notes of failure with a minimum of three other antidepressants, which may include MAOI. • Previous intolerance to a trial of oral MAOI. • No concurrent antidepressant therapy. • Initial authorization is 1 year - renewals require a telephone call from the physician's office of pharmacy. • Non-covered under Non-Traditional Medicaid.
Enzymes • Adagen	Adagen: • Documented diagnosis of Adenosine Deaminase Deficiency. • Copy of prescription from physician. • Dose must be delivered in pre-filled syringe for exact dosing. • Medicaid must be notified of changes in dosage with a copy of new prescription. • Authorization is for 1 year - renewals require a telephone call from the physician's office of pharmacy.
• Aldurazyme	Aldurazyme: • Documented and confirmed diagnosis of Hurler and Hurler-Scheie. • Confirmed diagnosis is defined as Hurler and Hurler Scheie of mucopolysaccharidosis I (MPS I) in patients with Scheie form who have severe symptoms. • Initial authorization is for 6 months - renewals require a telephone call from the physician's office or pharmacy.
• Aralast	Aralast: • Diagnosis of emphysema. • History of treatment, including current treatment and past treatment failures. • Explanation of condition that demands augmentation with Aralast. • Initial authorization is for 6 months - renewals are granted for 1 year periods with documentation of sustained improvement.
• Cerezyme	Cerezyme: • Documented diagnosis of Gaucher's Disease. • Copy of the prescription from physician. • Medicaid must be notified of changes in dosage with a copy of new prescription. • Initial authorization is for 6 months - renewals are granted in 1 year increments with documentation of significant improvement.
• Fabrazyme	Fabrazyme: • Documented deficient plasma or leukocyte a-galactisidase A (a-gal) OR • Documented a-gal deficiency and/or mutation in the a-gal A gene in heterozygous females. • Covered only for patients with documented ADA deficiency. • Initial authorization is for 6 months - renewals require a telephone request from the physician's office or pharmacy.
• Prolastin / Zemaira	Prolastin/Zemaira: • Documented Alpha-1 Antitrypsin deficiency AND • Documented Panacinar Emphysema. • Must have stopped smoking for at least 30 days, as documented by physician. • Initial authorization is for 6 months - renewals require a telephone request from the physician's office or pharmacy.

Drugs Requiring Prior Authorization	
Erythropoetins • Aranesp	Aranesp: • Diagnosis of anemia associated with renal failure or chemotherapy. • Patient is not on dialysis. • Patient does not have a GI bleed. • Hematocrit <33% supported by lab work done in the last 3 months (fax copy). • Hemoglobin <11% supported by lab work done in the last 3 months (fax copy). • Prescribing authority is granted to hematologist, oncologist, nephrologist, and infectious disease specialists, or based upon a consult with one of these specialists. • Initial authorization is granted for 6 months - renewals require that the patient not have GI bleeding, not be on dialysis, and lab work in the last 3 months showing hematocrit <39% and Hemoglobin 11-13% (fax copies).
• Procrit	Procrit: • Diagnosis of anemia associated with renal failure, chemotherapy, or HIV. • Blood transfusions, allogenic and anemic surgery patients (approve 1 time only). • Patient is not on dialysis. • Patient does not have a GI bleed. • Hematocrit <33% supported by lab work done in the last 3 months (fax copy). • Hemoglobin <11% supported by lab work done in the last 3 months (fax copy). • Prescribing authority is granted to hematologist, oncologist, nephrologist, and infectious disease specialists, or based upon a consult with one of these specialists. • Initial authorization is granted for 6 months - renewals require that the patient not have GI bleeding, not be on dialysis, and lab work in the last 3 months showing hematocrit <39% and Hemoglobin 11-13% (fax copies).
• Neupogen	Neupogen: • Documented myelosuppressive chemotherapy, bone marrow transplant, peripheral blood progenitor cell collection, severe chronic neutropenia. • Not covered for AIDS, hairy cell leukemia, myelodysplasia, drug-induced congenital agranulocytosis, alloimune neonatalneutropenia, Hepatitis C. • Initial authorization is granted for 6 months - renewals require a telephone request from the physician's office of pharmacy.
Growth Hormone for Adults *(AIDS Wasting Syndrome Only)*	• Minimum age - 19 years old. • Adult onset AIDS - AIDS Wasting indication only. • Body Mass Index is less than 20. • Patient must be taking antiretroviral medications. • Provide initial height and weight. • Rule out other causes of weight loss including hypogonadism (provide testosterone levels for men), opportunistic infections, diarrhea, inadequate nutritional intake, malabsorption, and thyroid abnormalities. • Patients must be able to maintain 100% of daily nutritional intake. For patients receiving enteral or parenteral nutrition, the patient must be weight stable for 2 months. • Patient must not have an untreated or suspected systemic infection or persistent fever > 101 F during the 30 days prior to evaluation of weight loss. • Patient must not have any signs or symptoms of gastrointestinal malabsorption or blockage unless on total parenteral nutrition. • Patient must not have active malignancy, except for Kaposi's Sarcoma. • Initial authorization is granted for a 60-day trial - renewals require a copy of the current history and physical showing weight gain. With appropriate progress, the patient may receive an additional four weeks of therapy. If the patient continues to show progress, additional prior authorizations are granted in 6 week periods to a maximum of 12 weeks in any 6 months.

Drugs Requiring Prior Authorization	
Growth Hormone • Children	1. Ages 0 - 18; must start before age 16 2. Height Stature <5th % on NCHS Growth Chart 3. Growth rate documented 6 months immediately prior 4. Must have: -Growth Failure due to: -Low Endogenous GH secretion <10ng/ml after provocative stimulation, AND low IGF-I levels as per the testing labs' ranges -documented chronic renal insufficiency up to time of renal transplant, or -Idiopathic short stature defined by SDS < 2.25 (Humatrope), OR -Turner Syndrome in patients with open epiphysis, OR -Short Bowel Syndrome in patients receiving specialized nutritional support, OR -Panhypopituatarism, OR -Small for gestational age (2 years max coverage): -requested before age 3 -normal GH levels or documented GH resistance -catch-up growth not shown before age 2 5. Completed sleep study for clients with Prader Willi 6. Prescribed by an endocrinologist or with endo consultation
Hepatitis Medications • Hepsera • Rebetron	Hepsera: • Diagnosis of hepatitis B. • Failure on Epivir. • 10mg/day is the maximum approved dose. • Initial authorization is granted for 12 weeks - renewals are granted in 12 month cycles with a telephone request from the physician's office or pharmacy. Rebetron: • Documented diagnosis of hepatitis C. • Patient must be severely ill. • Initial authorization is granted for 6 months - renewal requests require a letter of medical necessity documenting the current condition.
Increlex	• Patient age is between 2 and 18. • Documented diagnosis of Primary IGF-1 Deficiency. • GH and IGF-1 levels are at or below defined limits. • Patient does not have cancer. • Patient is not on chronic steroid therapy. • Patient does not have any uncorrected thyroid deficiencies. • Initial authorization is granted for 1 year - renewal requests require the same documentation as the initial request.

Drugs Requiring Prior Authorization	
Influenza Medications • Relenza • Tamiflu	Relenza: • Minimum age requirement: 7 years old. • Diagnosis of Influenza A or Influenza B. • Covered only for patients at high risk from diagnosed and documented disease states of immunodeficiency. This includes HIV/AIDS or other diseases of the immune system; long-term radiation treatment; long-term treatment with drugs such as steroids, oncology agents, or immunosuppressive agents; or fragility due to extreme age (greater than 65 years). • Prior Approval is limited to one box of 20 amps per year. • Treatment must be started within 72 hours or diagnosis. Tamiflu: • Minimum age requirement: 1 years old. • Diagnosis of Influenza A or Influenza B. • Covered only for patients at high risk from diagnosed and documented disease states of immunodeficiency. This includes HIV/AIDS or other diseases of the immune system; long-term radiation treatment; long-term treatment with drugs such as steroids, oncology agents, or immunosuppressive agents; or fragility due to extreme age (greater than 65 years). • Prior approval is limited to 10 capsules per year. OR • Prophylaxis for Influenza A or B for age 13 and older. • Documentation that demonstrates that one other household member or residential member currently has documented influenza A or B. • Covered only for patients at high risk from diagnosed and documented disease states of severe cardiopulmonary conditions, immuno-compromised patients, fragility due to extreme age (greater than 65 years). • Prior approval is limited to a 7-day course with 14 capsules. • TREATMENT MUST BE STARTED WITHIN 72 HOURS OF DIAGNOSIS.
Invega	• **Minimum age - 18 years old.** • **Diagnosis of schizophrenia.** • **Patient fails to take multiple daily doses of anti-psychotics and cannot tolerate a single daily dose of risperidone.** • **Initial authorization may be granted for 1 year - renewal requires a telephone call from the physician's office or pharmacy.**
Irritable Bowel Medication • Amitza	Amitza: • Minimum age requirement - 18 years old. • Diagnosis of Chronic Idiopathic Constipation. • Documented failure within the last 12 months using one fiber laxative and two stimulant laxative products. • Drug induced constipation must be ruled out. • Initial authorization is granted for 6 months - patient may have a second authorization after a trial off Amitza using other laxatives for at least 30 days. • The lifetime maximum is a total of 1 year of therapy with Amitza.
Lactulose	• Documented diagnosis of chronic liver failure, hepatic encephalopathy, chronic portal hypertension, or Spina Bifida. • Prior authorization is only required for > 6000ml's per month. • This drug will not be approved for use as general laxative for over 6000ml's monthly. • Initial authorization is granted for 6 months - renewals require a telephone call from the physician's office or pharmacy.
Lamisil	• Documented diagnosis of onychomycosis. • Coverage will be limited to 16 weeks per calendar year.

Drugs Requiring Prior Authorization	
LMWH Derivatives • Arixtra	Arixtra: • Pre-operative for 3 days to stop coumadin prior to surgery. • Post-operative for 5 days to achieve therapeutic INR on coumadin. • Post-operative prevention of DVT in patients with abdominal surgeries and below (i.e. hip, knee, and ankle not including foot and toes) for a maximum of 10 days. • Treatment of acute DVT or PE when administered in conjunction with coumadin, when initial therapy is administered in the hospital. • Re-authorization is considered on an individual basis and is based on INR.
• Fragmin	Fragmin: • Pre-operative for 3 days to stop coumadin prior to surgery. • Post-operative for 5 days to achieve therapeutic INR on coumadin. • Post-operative prevention of DVT in patients with abdominal surgeries and below (i.e. hip, knee, and ankle not including foot and toes) for a maximum of 10 days. • Treatment of acute DVT or PE when administered in conjunction with coumadin, when initial therapy is administered in the hospital. • Re-authorization is considered on an individual basis and is based on INR. • Ischemic complications in unstable angina and non-Q-wave MI patients on concurrent aspiring therapy for a maximum of 10 days. • Re-authorization is considered on an individual basis and is based on INR.
• Innohep	Innohep: • Documented diagnosis of a DVT or PE. • Treatment in conjunction with coumadin regulation and treatment for a maximum of 20 units in 10 days. • Re-authorization is considered on an individual basis and is based on INR. Requests may also be made by petition to the DUR Board.
• Lovenox	Lovenox: • Pre-operative for 3 days to stop coumadin prior to surgery. • Post-operative for 5 days to achieve therapeutic INR on coumadin. • Post-operative prevention of DVT in patients with abdominal surgeries and below (i.e. hip, knee, and ankle not including foot and toes) for a maximum of 10 days. • Treatment of acute DVT or PE when administered in conjunction with coumadin, when initial therapy is administered in the hospital. • Re-authorization is considered on an individual basis and is based on INR. • Ischemic complications in unstable angina and non-Q-wave MI patients on concurrent aspirin therapy for a maximum of 10 days. • Re-authorization is considered on an individual basis and is based on INR.
• Lovenox (Pregnancy):	Lovenox During Pregnancy: • Past history of DVT/PE OR • Active DVT/PE OR • Known hypercoagulability.
Myobloc	• Minimum age requirement: 12 years old. • Letter of medical necessity must include documentation and history of other treatments. • Approved for a documented diagnosis of cervical dystonia. • Treatment is covered every 3 months, not to exceed 10,000 units within 90 days. • Prior authorization is required when the medication is obtained through a pharmacy billing through the Point of Sale system. • Initial authorization is given for 6 months. Subsequent authorizations require documentation of patient progress.
Multiple Sclerosis Medications *(Avonex, Copaxone, Rebif)*	• Documented diagnosis of Multiple Sclerosis. • Initial authorization is granted for 1 year. Renewals require a telephone call from the physician's office or pharmacy.
Overactive Bladder Medications *(Ditropan XL, Detrol LA, Enablex, Sanctura, Vesicare, Oxytrol Patch)*	• Documented failure on short acting oral formulations of oxybutynin for 45 days within the last 12 months. • Initial authorization is granted for 1 year - renewals require a telephone call from the physician's office or pharmacy. • Oxytrol patch and Ditropan XL are non-covered for Non-Traditional Medicaid clients.

Drugs Requiring Prior Authorization	
Oxandrin	• First 60 day trial period: ▸ Minimum age requirement - age 19. ▸ Adult onset AIDS wasting indication only. ▸ BMI is less than 20 - provide current height, weight and BMI. ▸ Patient must be taking antiretroviral, documented. ▸ Patient must be maintaining a nutritional intake. • Authorization after 60 day trial (may approve for an additional 4 months): ▸ All criteria above remains effective. ▸ Weight needs to have been maintained or has increased. ▸ If weight has not maintained, it is no longer a benefit. Patient may need to advance to growth hormone. • Subsequent authorizations are granted in 6 month periods, and require documentation that the patient's weight has maintained or increased. Provide previous weight and current height.
Proton Pump Inhibitors	• Once daily dosing does not require an authorization - see page 7. • Prilosec OTC does not require a prior authorization for BID dosing. • Prior authorizations will be allowed for presenting acute states of GERD, ulcers, or hypersecretory conditions. • Documentation required includes a copy of an endoscopy report done within the last two years showing GERD or ulcers, or a copy of a hypersecretory study showing the hypersecretory condition. • Initial authorization is granted for two months. BID dosing for longer than 2 months requires special approval from the DUR board.
Provigil	• Minimum age requirement - age 9. • Covered for the following diagnoses: ▸ Narcolepsy - Amphetamines or Methylphenidate must be tried first. Dose is limited to 400mg daily. ▸ Treatment to offset sedation related to multiple sclerosis treatment modalities. Dose is limited to 200mg daily. ▸ Daytime somnolence due to obstructive sleep apnea - must be on C-pap. Dose is limited to 200mg daily. • Initial authorization is granted for 1 year - renewals require a telephone call from the physician's office or pharmacy.

Drugs Requiring Prior Authorization	
Pulmonary Anti-hypertensives • Flolan	Flolan: • Covered only for patients with documented Primary Pulmonary Hypertension. • If patient has a history of substance abuse, the patient must successfully complete a substance abuse rehabilitation program immediately before being placed on Flolan, or must have documented abstinence (urine or blood test) for a period of at least six months. (Repeat on authorization renewal) • Initial authorization is granted for 6 months - renewals require an updated letter of medical necessity showing patient progress and repeat urine or blood test showing that patient is not having a problem with substance abuse.
• Remodulin	Remodulin: • Documented diagnosis of Primary Pulmonary Hypertension. • Initial authorization is granted for 1 year - renewals require a telephone call from the physician's office or pharmacy.
• Revatio	Revatio: • Documented diagnosis of Primary Pulmonary Hypertension. • Initial authorization is granted for 1 year - renewals require a letter or progress note indicating improvement or maintenance with the medication.
• Tracleer	Tracleer: • Minimum age requirement - 12 years old. • Documented WHO (World Health Organization) diagnosis of class III or IV Pulmonary Arterial Hypertension. • Copy of prescription from physician. • Contraindicated for patients with moderate to severe liver impairment and patients taking cyclosporin or glyburide. • Females cannot be capable of becoming pregnant. • Dose is 62.5mg BID for 4 weeks, increased to a maximum of 125mg BID. • Initial authorization is granted for 1 year - renewal request requires a telephone call from the physician's office or pharmacy.
• Ventavis	Ventavis: • Documented WHO group I NYHA class III or IV Pulmonary Arterial Hypertension. • Documented failure on Flolan and Remodulin and Revatio and Tracleer. • Not for simultaneous use with Flolan, Remodulin, Revatio, or Tracleer. • Submit a copy of the prescription from the physician. • Initial authorization is granted for 1 year - renewals require a telephone call from physician's office or pharmacy.
Regranex	• Rule out venous ulcers and/or arterial ulcers. • Patient must be diabetic, either type I or type II. • Not covered for diabetic ulcers above the ankle. • Patient must have stage III or IV diabetic foot or ankle ulcer as per the International Association of Enterostomal therapy guide to chronic wound staging 1989. • Not a benefit for patients in long term care facilities, unless that patient is admitted from home or hospital with a pre-existing diabetic ulcer of the lower extremity. LTCF must submit a copy of skin assessment report made within 24 hours of admission. • The client must have had a documented failure on a 60 day regimen of good ulcer care that includes but is not limited to: 1. Initial complete sharp debridement. 2. A non-weight bearing regimen. 3. Systemic treatment for wound-related infections. 4. Moist saline dressing changes twice daily. 5. Additional debridement If necessary. • The subcutaneous ulcer may not exceed 3cm in diameter or total surface of 9.42cm^2 (size and shape must be documented). • Total contact casting is an available method of treatment and must be considered and rejected before Regranex is to be considered. • Initial authorization may be granted for 8 weeks and 15-30gm - renewal requires a second PA application demonstrating a 30% reduction in ulcer size. • Treatment is limited to 60gm of Regranex.

Drugs Requiring Prior Authorization	
Renal Cell Carcinoma Meds • Nexevar • Sutent	Nexevar: • Minimum age requirement: 18 years old. • Diagnosis of advanced renal cell carcinoma. • Initial authorization is granted for 400mg BID until no benefit or side-effects are intolerable - renewal requests are granted with a telephone call from the physician's office or pharmacy. • Nexevar is available only through 5 specialty pharmacies via mail-order: Caremark, Curascript, Accredo, Pharmacare, or McKesson Specialty. Sutent: • Minimum age requirement 18 years old. • Diagnosis and documentation of advanced renal cell carcinoma. • History of other treatments, including documented disease progression on or intolerance to Gleevec. • Initial authorization is granted for 50mg daily, 4 weeks on and 2 weeks off. Dose increases or reductions by 12.5mg increments approved as needed or tolerated. Renewals may be granted with a telephone call from the physician's office or pharmacy.
Restasis	• Approved for the following diagnoses (ICD.9: ▸ 370.20 (Superficial keratitis, unspecified) ▸ 370.21 (Punctate keratitis) ▸ 370.33 (Keratoconjunctivitis sicca, not specified as Sjogren's disease) ▸ 710.2 (Sicca syndrome - Sjogren's disease) • Documentation requirements for the above diagnoses: 1. Diagnosis. 2. Documented fluorescein test. 3. Request from opthamologist or with documented opthamologist consult. • Prior approval for the above diagnoses is granted for 1 year - renewals require a new PA request. OR • Documented corneal transplant (ICD.9 V 42.5) • Initial authorization is granted for 1 year - renewals granted with a telephone call from physician's office or pharmacy.
Retinoids • Panretin	Panretin: • Initial 30-day trial period: ▸ Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma ▸ Documentation of primary number of KS lesions, estimated total square centimeters, number of lesions flat on baseline, and number of lesions raised on baseline. ▸ Systemic anti-KS therapy is not yet required. ▸ Retin-A 0.1% gel has been tried for a period of 60 or more days, and there was less than a 25% improvement of both partial response area and partial response height. • 60 day treatment period: ▸ Patient must sustain partial response defined as a 50% or more improvement from base line. ▸ Documentation of primary number of KS lesions, estimated total square centimeters, partial response area, and partial response height. • Re-authorization may be granted for additional treatment of 60 day periods with continued improvement documented as above.

Drugs Requiring Prior Authorization	
• Retin-A	Retin-A: • Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma. • Pre-pancretin use. • Documentation of primary number of KS lesions, estimated total square centimeters, number of lesions flat on baseline, and number of lesions raised on baseline. • Systemic anti-KS therapy is not yet required. • Initial authorization is granted for a 60-day trial period. Re-authorization is given for 6 month periods with documentation indicating that the patient has had at least a 25% improvement from baseline.
Risperdal Consta	• Minimum age requirement - 18 years old. • Documentation of patient diagnosis (open for the same ICD-9 codes as oral risperdal). • Documentation that the patient is unresponsive to conventional treatment. • Documentation that the patient is non-compliant with previous treatment modalities. • Drug must be administered in a clinic or physician office, NOT approved for nursing homes or group homes. • The initial prior approval must be obtained by a prescriber associated with a capitated mental health plan. • Approved only for one injection at two-week intervals. • Initial authorization is granted for one year - renewal requests require a telephone call from the physician's office.
Selzentry	• Minimum age requirement - 16 years old. • Documentation of co-receptor tropism assay test indicating CCR5-tropic HIV-1 infection. • Documentation of optimized background therapy for the treatment of HIV-1 infection. • Initial authorization is for 12 months - renewal requests require a telephone call from the physician's office or pharmacy.
Soliris	• Documented diagnosis of paroxysmal nocturnal hemoglobinuria. • Documented failure of or intolerance to other PNH treatments, including transfusion. • Review by the DUR Board.
Somavert	• Documented acromegaly. • Documentation showing inadequate response to either transsphenoidal adenomectomy or radiotherapy or both. • Documented trial on at least one dopamine agonist such as cabergoline or bromocriptine. • Documentation that the patient has been evaluated for a somatostatin analogue such as octreotide acetate. • Initial authorization is granted for one year - renewal requests require a telephone call from the physician's office of pharmacy.

Drugs Requiring Prior Authorization	
Stimulants • Daytrana Patch	Daytrana: • Age requirement: 6-18 years old. • Documentation of physical inability to swallow. OR • Documentation that patient is currently on a combination of two stimulants or stimulant(s) and Strattera or that patient is on two different strengths of the same ADD/ADHD medication - Daytrana must be a more cost-effective therapy. • No previous therapeutic failure on other methylphenidate preparations. • Initial authorization is granted for 1 year - renewal requests require an updated letter of medical necessity. • Not covered for Non-Traditional Medicaid
• Adult ADHD Stimulants	Adult ADHD Stimulants: • Documented Diagnosis of one of the following: ADD, ADHD, narcolepsy, organic brain syndrome, traumatic brain injury, treatment resistant depression, mental retardation (if the patient exhibits injurious behavior, is hyperactive, or both), severe sedation due to psychotropic or chemotherapeutic medications. • Letter of medical necessity stating current treatment and situation. • Depression diagnosis requires a description of treatment history and failures. • Adult ADD/ADHD diagnosis requires a copy of the testing that has been done to make the diagnosis of adult ADD/ADHD. Acceptable testing for adult ADD/ADHD includes a psychiatric evaluation, Wender Utah Rating Scale scoring 46 or greater, documentation of the criteria that have been met from the DSM IV manual. • Statement documenting and substance abuse problems past or present, or a statement indicating no substance abuse history. • Initial authorization may be granted for one year - renewal requests require an updated medical necessity and an updated substance abuse statement.
• **Vyvanse**	Vyvanse: • Therapy to be initiated between the FDA-approved ages of 6 - 12. • Documented diagnosis of ADHD. • Vyvanse must be more cost-effective than the patient's current ADHD therapy. • Vyvanse must follow an unsuccessful trial of a dextroamphetamine. • Initial authorization is granted for 1 year - renewal request requires a telephone call from the physician's office.
Synagis	• Infants of 28 week gestation may receive Synagis prophylactically during the first year of life. • Infants of 29-35 weeks gestation may receive Synagis prophylactically during the 1st to 6th month of life. • Any children under 24 months may receive Synagis if they have either 1. Clinical diagnosis of Broncho Pulmonary Dysplasia (BPD) requiring ongoing medical treatment OR 2. Hemodynamically significant Congenital Heart Disease (CHD) requiring ongoing treatment. • Criteria for coverage through a pharmacy: 1. Be home bound; and, 2. The pharmacy must bill using correct NDC numbers. • Synagis is not available to any child with active RSV. • The Utah Medicaid Synagis season is for a 6 month period beginning November 1. • A total of 5 immunizations during this 6 month period will be approved, except when the patient begins the immunizations late in the season. • A child who has started the series and then turns 2 may continue to a total of 5 immunizations or to the end of the season, whichever comes first. • No approval will be given to a child 24 months of age or older. • Physicians who provide the vaccine in the office should use code 90378 and the appropriate administration code for reimbursement.
Trizivir	• Documented failure of all three medications (Abacavir, Lamivudine, and Zidovudine) individually. • Initial authorization may be granted for 1 year - renewal requests require a telephone call from the physician's office or pharmacy.

Drugs Requiring Prior Authorization	
Tykerb	• Minimum age: 18 years old. • Diagnosis of advanced or metastatic breast cancer whose tumor overexpresses HER2. • Prior therapy, including an anthracycline, a taxane, and trastuzumab. • To be given in combination with capecitabine. • Prior authorization is given for 1 year - renewal requires an updated letter of medical necessity.
Vectibix	• Minimum age - 18 years old. • Diagnosis of metastatic colorectal cancer. • Disease progression on or following fluoropyrimidine-, oxplatin-, and inrinoteacan-containing chemotherapy regimens. • Initial authorization may be granted for 1 year - renewal requires an updated letter of medical necessity.
Vivitrol	• Diagnosis of alcohol abuse. • Negative urine screen for opioids or passed naloxone challenge. • Description of the psychosocial support to be received by the patient, as indicated by chart notes or a brief letter of medical necessity. • Negative screen for liver problems.
Xanax XR	• Documentation of failure on a 6-8 week trial of short-acting oral alprazolam within the last 6 months. • Initial authorization may be granted for 1 year - renewal requests require a telephone call from the physician's office or pharmacy. • Non-covered under Non-Traditional Medicaid.
Xibrom	• Prior trial of any indicated medication. • Approved for one bottle for a 2 week period following procedure or surgery.
Xolair	• Minimum age requirement - 12 years of age. • Diagnosis of moderate to severe persistent asthma of at least 1 year duration OR • Diagnosis of allergic conjunctivitis and rhinitis, atopic dermatitis, and food allergy. • Documented positive skin test reaction to a perennial aeroallergen. • Documentation showing symptoms are inadequately controlled with inhaled corticosteroids and beta-agonists. • Documented forced expiratory volume in one second (FEVI) < 70% predicted (It is possible for severe asthmatics to be better than 70% FEVI on rescue therapy, but they would still struggle with optimum maintenance therapy. In such severe cases, Xolair would be considered for approval). • Documented pulmonologist or allergist consultation within the last 60 days. • Body weight > 30kg and < 150kg. • Baseline total serum IgE >30 and < 700 IU/ml. • Patient prescription claim history must demonstrate routine use of inhaled corticosteroids for a 90 day period. • Initial authorization may be granted for 6 months - renewal requests require a telephone call from the physician's office or pharmacy.
Xolegel	• Minimum age: 12 years old. • Documented trial and failure of a generic formulation of topical ketoconazole within the last 12 months. • Prior authorization is given for 6 months - renewal requests require a telephone call from the physician's office or pharmacy.
Xyrem	• Age requirement - 18 to 65 years old. • Documented cataplexy associated with narcolepsy. • Documentation ruling out concomitant use of sedative-hypnotics. • Maximum dose is 9gm/day • Initial authorization may be granted for 1 year - renewal requests require a telephone call from the physician's office or pharmacy.

Drugs Requiring Prior Authorization	
Zavesca	• Minimum age requirement - 18 years old. • Diagnosis of moderate type I Gaucher's disease. • Documentation that enzyme replacement therapy has failed. • Platelet count > 50k/ul (FAX a copy of the lab work) • Written consultation with a trained specialist (hematologist or geneticist) • Cumulative limit of 90 capsules in 30 days. • Initial authorization period may be granted for 1 year - renewal requests require a telephone call from physician's office or pharmacy
Ziana	• Age requirement - 12-19 years old. • Patient must try and fail on a combination of both generic tretinoin gel and clindamycin gel. • Initial authorization may be granted for 1 year - renewal requires an updated letter of medical necessity.

Utah Medicaid Pharmacy Services

Request for Prior Authorization

Request Date_____

Patient Name_____

Patient DOB _____/_____/_____Medicaid ID #_____

Social Security Number (if Medicaid ID# unknown)_____

Pharmacy Name_____

Pharmacy Telephone Number_____

Drug Name and Strength_____

Dosage_____

Prescriber Name_____ National Provider ID_____

Prescriber Telephone#_____ Prescriber Fax #_____

Diagnosis:

Date of Diagnosis:

Attach Supporting Documentation

Total Pages_____

Instructions for submitting this PA Request

- Prior Authorizations are only accepted by fax.
- The form may be completed electronically or *legibly* by hand.
- It is not mandatory to use this cover letter; however all of the information requested on this form is necessary before a prior authorization request can be initiated.
- Fax all necessary documentation to the Medicaid Prior Authorizations Team at the following numbers: (801)536-0964 or (801)536-0960 or (801)536-0959.

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